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PLAYING GOD: FAULTY DECISION-MAKING IN MEDICAL FUTILITY DISPUTES

C. Scott Sergeant[†]

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Baby Tinslee Lewis was born in late February 2019 with a rare heart defect and was placed on extracorporeal membrane oxygenation, a machine that fulfilled the functions of her heart and lungs.¹ By the time she was ten months old, Cook Children's Medical Center in Fort Worth, Texas, stated that her condition required long-term life-sustaining treatment and that simple palliative care such as feeding and bathing could cause serious complications.² Her physicians wanted to terminate their care for Tinslee because they believed that continuing care was only postponing an inevitable death, but Tinslee's mother wanted to continue treatment.³

Cook Children's Hospital determined that further treatment of Tinslee would be futile, and her mother was forced to begin a search for other providers willing to accept the child.⁴ After contacting over twenty hospitals, none were willing to accept a child in such critical condition.⁵ On December 4, 2019, Cook Children's Hospital officially reported that no facilities were willing to accept Tinslee, thus triggering a ten-day waiting period required by law under the Texas Advanced Directives Act (TADA)

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¹ Charlotte Huff, *Texas Law Highlights Dilemma Over Care for Patients with no Hope of Survival*, KAISER HEALTH NEWS (Dec. 23, 2019), <https://khn.org/news/texas-law-highlights-dilemma-over-care-for-patients-with-no-hope-of-survival/> [<https://perma.cc/7D7H-7K2H>].

² *Id.*

³ Kaley Johnson, *Caring for Fort Worth Baby on Life Support is 'Emotionally Difficult,' her Nurse Says*, FORT WORTH STAR-TELEGRAM (Mar. 1, 2020), <https://www.star-telegram.com/news/local/fort-worth/article240692506.html> [<https://perma.cc/YG6C-PUGG>].

⁴ Huff, *supra* note 1.

⁵ *Id.*

before life-sustaining treatment could be terminated without parental consent.⁶

If, by the end of the ten days, Tinslee's mother could not find a facility willing to accept her, then Cook Children's Medical Center could stop treatment, effectively terminating her life.⁷ Tinslee's family secured a temporary restraining order against the hospital until January 2, 2020, at which time the hospital was free to terminate care.⁸ Tinslee's family, continuing to fight for her life, argued her case to continue treatment in front of the Texas State Court of Appeals in Fort Worth on February 4, 2020.⁹ As of March 1, 2020, the court has not issued an opinion.¹⁰

Medical futility disputes like Tinslee's can be some of the most frustrating problems facing healthcare professionals.¹¹ This article will consider medical futility disputes such as Tinslee's and how the faulty allocation of decision-making power currently plaguing these disputes can be alleviated by incorporating elements of the precautionary principle. Part I discusses factors common to futility disputes that make such disputes particularly contentious. Part II discusses the definitional approach to medical futility disputes and the shortcomings of this method. Part III discusses the modern process-based approach to solving medical futility disputes and its shortcomings. Part IV discusses the precautionary principle and its role as a decision-making tool for environmental protection. Finally, Part V shows how the major problems discussed in Parts II and III are solved by applying the framework of the precautionary principle to medical futility disputes.

I. A BRIEF LOOK AT THE COMMON FEATURES OF MEDICAL FUTILITY DISPUTES

As is clear from the story of Tinslee Lewis, medical futility disputes are fraught with difficulty. While medical futility has proven difficult to define specifically, it arises when a physician believes continuing treatment is medically or ethically inappropriate, but the patient or surrogate

⁶ *Id.*

⁷ *Id.*

⁸ *Id.*

⁹ Johnson, *supra* note 3.

¹⁰ *Id.* On January 2, 2020, a second request for a temporary injunction was denied. On July 24, 2020, the Second Court of Appeals reversed the denial of the temporary injunction and remanded for further proceedings. The Texas Supreme Court declined to hear the case. Daniel Friend, *Cook Children's Motion in Tinslee Lewis Case Denied by Texas Supreme Court, Child to Remain on Life Support*, THE TEXAN (Oct. 19, 2020), <https://thetexan.news/cook-childrens-motion-in-tinslee-lewis-case-denied-by-texas-supreme-court-child-to-remain-on-life-support/> [https://perma.cc/R6N9-JE9A].

¹¹ Robert D. Truog, *Medical Futility*, 25 GA. ST. U. L. REV. 985, 986 (2009).

disagrees, preferring to continue treatment.¹² There are several factors that make medical futility disputes particularly contentious: the life-and-death stakes,¹³ allocation of scarce medical resources,¹⁴ and differing faith or values.¹⁵

Most medical futility disputes arise over the beginning or continuation of life-sustaining medical treatment.¹⁶ The Supreme Court noted in *Cruzan v. Director of the Missouri Department of Health* that heightened interests exist when medical decisions will likely result in the death of the patient.¹⁷ These life-and-death decisions are “deeply personal” and “overwhelmingly final” for all parties involved.¹⁸ Because such disputes center on life-sustaining treatment, “withholding or withdrawing life-sustaining medical treatment will result in the patient’s death.”¹⁹ Not only do the family members have strong feelings about these decisions,²⁰ but so also does the state, as demonstrated by the severity of punishment for murders and laws against assisted suicide.²¹ There is no disinterested party.

In addition to the interests of life and death, there is the unavoidable issue of conservation of medical resources.²² Medical futility cases almost always involve questions of healthcare costs and allocation of resources.²³ For example, a futility dispute would not arise over a surrogate’s demand for vitamin C to treat an aggressive form of cancer, even though it would have no meaningful effect on the disease and could be considered futile.²⁴ Conversely, if the same patient requested a limited treatment that was prohibitively expensive with little or no chance of success, then a physician would be more likely to object to expending that treatment on such a patient.²⁵ While futility disputes and conservation of resources seem

¹² See Jon D. Feldhammer, *Medical Torture: End of Life Decision-Making in the United Kingdom and United States*, 14 CARDOZO J. INT’L & COMP. L. 511, 520 (2006).

¹³ Thaddeus Mason Pope, *Procedural Due Process and Intramural Hospital Dispute Resolution Mechanisms: The Texas Advance Directives Act*, 10 ST. LOUIS U.J. HEALTH L. & POL’Y 93, 97 (2017) [hereinafter Pope, *Procedural Due Process*].

¹⁴ Truog, *supra* note 11, at 990.

¹⁵ Teneille R. Brown, *Medical Futility and Religious Free Exercise*, 15 FIRST AMEND. L. REV. 43, 53–54 (2016).

¹⁶ Pope, *Procedural Due Process*, *supra* note 13, at 97.

¹⁷ 497 U.S. 261, 281 (1990).

¹⁸ *Id.*

¹⁹ Thaddeus Mason Pope, *Dispute Resolution Mechanisms for Intractable Medical Futility Disputes*, 58 N.Y.L. SCH. L. REV. 347, 351 (2014) [hereinafter Pope, *Dispute Resolution Mechanisms*].

²⁰ *Cruzan*, 497 U.S. at 286.

²¹ *Id.* at 280.

²² Truog, *supra* note 11, at 990.

²³ *Id.* at 990–91.

²⁴ *Id.* at 991.

²⁵ *Id.*

to go hand in hand,²⁶ scholars like Schneiderman have pointed out that money or rationing of medical resources and futility determinations are separate considerations.²⁷ Rationing refers only to the allocation of scarce treatments among patients, whereas futility involves determining how beneficial those treatments will be to a given patient.²⁸ Thus, determining futility and denial of care to a patient should have nothing to do with allocating medical resources.²⁹

The final difficulty concerning medical futility disputes is the differing concepts of faith and morals that arise between the patient or surrogate and their physicians. For example, in the Roman Catholic tradition, persons have the moral obligation to provide and receive care for medical ailments.³⁰ This duty extends to those surrounding and caring for the patient.³¹ However, the duty to give and accept care is not mandated in every situation.³² Pope Pius XII stated that man has the right and moral obligation to take necessary treatment for the preservation of life and health, but this normally extends only to ordinary means that do not involve grave burdens for oneself or another.³³ Thus, if the medical treatment is ordinary, then a physician is morally obliged to offer such treatment, but if it is extraordinary, then there is no moral obligation for the physician or patient to pursue it.³⁴ In other words, a Catholic patient or their surrogate could be morally bound to make a decision out of a sense of duty, which is not shared by a secular healthcare provider.³⁵

Tensions involving religious beliefs are prevalent in medical futility disputes because religious fervor and moral convictions often increase the closer one is to death.³⁶ However, doctors have become more secular and less concerned with their patient's newly discovered spiritual

²⁶ *Id.* at 990–91.

²⁷ Lawrence J. Schneiderman, Nancy S. Jecker & Albert R. Jonsen, *Medical Futility: Response to Critiques*, 125 ANNALS OF INTERNAL MED. 669, 673 (1996) [hereinafter Schneiderman et al., *Medical Futility: Response to Critiques*].

²⁸ *Id.*

²⁹ *Id.* See also Truog, *supra* note 11, at 990.

³⁰ Pope Pius XII, *The Prolongation of Life*, 9 NAT'L CATH. BIOETHICS Q. 327, 329 (2009).

³¹ *Id.*

³² *Id.*

³³ *Id.*

³⁴ Peter A. Clark, *Medical Futility: Legal and Ethical Analysis*, 9 AM. MED. ASS'N J. ETHICS 375, 382 n.23 (2007) ("Ordinary means of preserving life are all medicines, treatments, and operations, which offer a reasonable hope of benefit for the patient and which can be obtained and used without excessive expense, pain or other inconvenience, [e]xtraordinary means are all medicines, treatments, and operations, which cannot be obtained or used without excessive expense, pain or other inconvenience, or which if used, would not offer a reasonable hope of benefit.") (citation omitted).

³⁵ See Brown, *supra* note 15, at 44.

³⁶ *Id.* at 49.

fervor.³⁷ The increased separation between the spirituality of the patient and their physicians often causes difficulty and conflict in determining end-of-life care.³⁸ This disconnect, resulting from opposing viewpoints between religious patients and their secular counterparts, can cause an increase in the percentage of futility disputes.³⁹ The particular factors of life-and-death stakes, rationing of medical resources, and an increase in spiritual faith or values, while only a few of the difficulties involved in medical futility disputes,⁴⁰ paint a picture of the quagmire that policymakers, legislators, scholars, and physicians must wade through to reach a morally amicable solution between patients, their surrogates, and physicians.

II. THE DEFINITIONAL APPROACH TO MEDICAL FUTILITY

Scholars attempted to balance the competing factors in medical futility disputes and find a workable resolution to futility disputes by defining medical futility.⁴¹ In 1990, Schneiderman and other experts in the field of medical futility proposed a method by which doctors could terminate care in medically-futile cases based on an objective determination of medical futility.⁴² The definitional approach to medical futility states that if a physician determines that a treatment meets the criteria for futility, then such treatment should be withheld.⁴³ Under this definitional approach, the futility determination would be made by the physician, consulting with other healthcare professionals but without input or consent from the family or surrogate.⁴⁴

Schneiderman's first step in defining futility was to consider the ultimate goal of the treatment and distinguish it from a physiological effect of treatment.⁴⁵ Certain treatments can have a desired and expected physiological effect. But if those effects do not move the patient closer

³⁷ See *id.* at 51–52 (discussing religion, hospital service, and death in modern hospitals).

³⁸ *Id.* at 52.

³⁹ Lucas S. Zier, Jeffrey H. Burack, Guy Micco, Anne K. Chipman, James A. Frank & Douglas B. White, *Surrogate Decision Makers' Responses to Physicians' Predictions of Medical Futility*, 136 CHEST 110, 114 (2009).

⁴⁰ This note will not attempt to address all aspects of medical futility because "it is the [better] part of wisdom not to attempt, by any general statement, to cover every possible phase of the subject." *Cruzan v. Dir. Mo. Dep't of Health*, 497 U.S. 261, 278 (1990) (quoting *Twin City Bank v. Nebeker*, 167 U.S. 196 (1897)).

⁴¹ Lawrence J. Schneiderman, Nancy S. Jecker & Albert R. Jonsen, *Medical Futility: Its Meaning and Ethical Implications*, 112 ANNALS INTERNAL MED. 949, 949 (1990) [hereinafter Schneiderman et al., *Medical Futility: Its Meaning*].

⁴² *Id.*

⁴³ *Id.*

⁴⁴ *Id.*

⁴⁵ *Id.* at 950.

toward their ultimate goal of recovery, then it is futile.⁴⁶ For example, insulin given to a patient sick with pneumonia would produce the desired physiological effect on the patient's blood sugar but would in no way affect the ultimate goal of curing the patient of pneumonia.⁴⁷ Or, in more chilling terms, "nutritional support could effectively preserve a host of organ systems in a patient in persistent vegetative state, but fail to restore a conscious and sapient life."⁴⁸ Hence, treatments that fail to restore well-being or a general state of health are considered futile by Schneiderman's definitional approach, and the physician in those cases should terminate treatment.⁴⁹ Distinguishing the physiological effect from the ultimate goal of treatment allows the attainability of the end goal to become the standard by which treatment is deemed successful or futile.⁵⁰ If the treatment will achieve the goal of restoring a patient to health, then it is not futile, but if it will not restore health, then it is futile. According to Schneiderman, the physician should have the sole power to determine the goal of the patient and what treatments will or will not achieve that goal, giving him the sole power in a futility dispute.⁵¹

Schneiderman proposed two separate thresholds for determining medical futility: quantitative and qualitative.⁵² Quantitative futility exists when there is a low probability of success in achieving the end goal of a state of health.⁵³ Schneiderman proposed a one-percent quantitative threshold, stating that "when physicians conclude . . . that in the last 100 cases, a medical treatment has been useless, they should regard it as futile."⁵⁴ This one-percent rule can be based either on the doctor's experience or on empirical studies,⁵⁵ both of which completely exclude the family or surrogate and render them powerless.⁵⁶

Qualitative futility exists when the treatment does not produce a beneficial outcome that would allow a patient to lead a meaningful life, even if it has the desired physiological effect.⁵⁷ Under qualitative futility, once the doctor determines that the end goal of restoring a "meaningful" life is no longer achievable, the patient and surrogate lose the right to choose their

⁴⁶ *Id.*

⁴⁷ *Id.*

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ *See id.*

⁵² *Id.* at 951.

⁵³ *Id.*

⁵⁴ *Id.*

⁵⁵ *Id.* at 951-52.

⁵⁶ *Id.* at 952-53.

⁵⁷ *Id.*

treatment plan, and the doctor may terminate care.⁵⁸ This is because “the patient has no right to be sustained in a state in which he or she has no purpose other than mere vegetative survival; the physician has no obligation to offer this option or services to achieve it.”⁵⁹ This loss of the right to choose treatment is not limited simply to patients existing in persistent vegetative states.⁶⁰ Schneiderman extends the qualitative futility determination to include patients whose future predictable lives would be regulated to “constant monitoring, ventilatory support, and intensive care nursing . . . [or] overwhelming suffering.”⁶¹ Under the qualitative threshold, the physician extends their professional discretion over and above human life, making a value-laden decision about the patient’s quality of life.⁶² If, in their opinion, the patient cannot “achieve any other life goals,” then treatment ought to be terminated.⁶³

The first difficulty with a quantitative approach to determining futility arises with accurately determining the likelihood that the treatment will be successful.⁶⁴ Scoring systems in intensive care units attempt to determine futility quantitatively by taking into account factors like “poor prognosis, minimal chance of survival, and high probability of death.”⁶⁵ However, these techniques for determining a percentage of success for a given treatment were developed with large samples and thus can be misleading when applied to a particular individual.⁶⁶

Reaching a high level of certainty regarding the effectiveness of treatments in particular cases is difficult.⁶⁷ Some studies claim that a particular treatment in certain circumstances will have a one hundred percent mortality rate but fail to include a sample size large enough to exclude the possibility that some individuals may survive.⁶⁸ Other studies claim that a treatment is medically futile but fail to actually meet the most common standard—less than one percent success rate—for quantitative futility.⁶⁹

⁵⁸ *Id.*

⁵⁹ *Id.* at 952.

⁶⁰ *Id.*

⁶¹ *Id.*

⁶² *Id.*

⁶³ *Id.* at 952–53.

⁶⁴ See Maryam Aghabarary & Nahid Dehghan Nayeri, *Medical Futility and Its Challenges: A Review Study*, J. MED. ETHICS & HIST. MED. (Oct. 20, 2016), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5203684> [https://perma.cc/X4YP-SBSB].

⁶⁵ *Id.*

⁶⁶ *Id.*

⁶⁷ See Dominic J. Wilkinson & Julian Savulescu, *Knowing When to Stop: Futility in the Intensive Care Unit*, 24 CURRENT OP. ANESTHESIOLOGY 160, 161 (2011), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3252683/> [https://perma.cc/2L2K-HURN].

⁶⁸ *Id.* at 162.

⁶⁹ Aghabarary & Dehghan, *supra* note 64.

In addition to the difficulties of accurately predicting the chance of success,⁷⁰ attaching a percentage-based threshold to futility and terminating treatment based on that percentage becomes a self-fulfilling prophecy.⁷¹ When life support or other medical treatment is removed “because of a predicted high risk of dying, the measured mortality rates will be artificially elevated.”⁷² Establishing an artificial percentage-based threshold at which the patient’s life will be effectively terminated contributes to the mortality rate, only further entrenching and solidifying the artificially high statistics upon which the percentage is based.⁷³

Even if a physician were to know with absolute certainty that the chance of success is less than one percent, this statistical certainty does not solve the actual dispute between the physician and the patient or surrogate.⁷⁴ A bright-line rule for a medical futility determination does not end the conflict because futility judgments are subjective.⁷⁵ A doctor may believe that the chance of recovery is very low, but to a patient or their surrogate, any chance may be worth the risk.⁷⁶ A study published by the American College of Chest Physicians indicated that thirty-two percent of surrogates would choose to continue life support even when there was less than one percent chance of survival.⁷⁷ Even presented with no chance of survival, eighteen percent of surrogates would still choose to maintain life support.⁷⁸

Furthermore, patients and surrogates with religious convictions are more likely to continue life support than their secular counterparts.⁷⁹ For a patient and their family, “a chance of one percent is much better than no chance.”⁸⁰ Thus, even though physicians attempt to standardize their futility determinations, their quantitative results are considered subjectively by the patients, and thus the conflict between physicians and surrogates cannot be resolved by a quantitative definition of futility.

In considering the qualitative definition of futility, similar difficulties arise.⁸¹ When making a futility determination based on qualitative futility, the doctor passes judgment not only on whether the patient’s goals are

⁷⁰ *See id.*

⁷¹ Wilkinson & Savulescu, *supra* note 67, at 162.

⁷² *Id.*

⁷³ *See id.*

⁷⁴ *Id.* at 161.

⁷⁵ *Id.*

⁷⁶ *Id.*

⁷⁷ Zier et al., *supra* note 39, at 114.

⁷⁸ *Id.*

⁷⁹ *Id.*

⁸⁰ Aghabarary & Dehghan, *supra* note 64.

⁸¹ *See* Thaddeus Mason Pope, *Medical Futility Statutes: No Safe Harbor to Unilaterally Refuse Life-Sustaining Treatment*, 75 TENN. L. REV. 1, 5 (2007) [hereinafter Pope, *Medical Futility Statutes*].

achievable (as with quantitative futility) but also whether those goals are worthwhile.⁸² A doctor may determine that a treatment has little or no value because, from their point of view, the patient's future life will be too debilitating to be valuable.⁸³ However, when faced with equating the value of a life based on the quality of life, the Supreme Court of Massachusetts stated that "to the extent that this formulation equates value of life with any measure of quality of life, we firmly reject it."⁸⁴

The Massachusetts court voiced a common criticism of qualitative futility.⁸⁵ While it is acceptable for someone, of their own volition, to forgo medical treatment based on their future quality of life,⁸⁶ a physician cannot reasonably determine when a life becomes worthless any more than "nine people picked at random from the Kansas City telephone directory."⁸⁷ In fact, doctors can be "poor predictors of a patient's quality of life."⁸⁸ The difficulty in selecting the physician as the sole arbiter of the value of life is that families, surrogates, doctors, ethicists, and theologians all consider the life of an individual in different ways.⁸⁹

The fundamental problem with both the quantitative and qualitative approach to determining medical futility lies in deciding who has the power to judge whether the life is valuable enough to justify the treatment.⁹⁰ The definitional approach places the power to make life-and-death value judgments in the hands of physicians who, even with their many medical qualifications, are unqualified to determine the value of another person's life.⁹¹ Because the concepts of medical futility, value of life, and likelihood of recovery are complex, ambiguous, and subjective, determining these "concepts solely from the perspectives of healthcare professionals would not be valuable, because their perspective toward utility [quantitative] and outcome [qualitative] may differ from that of the patients and their families."⁹² In making a medical futility determination based on a definitional approach to futility, the views of the patient, family, and surrogate are not considered.⁹³

⁸² *Id.* at 34.

⁸³ *Id.* at 39.

⁸⁴ *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 432 (Mass. 1977).

⁸⁵ See Pope, *Medical Futility Statutes*, *supra* note 81, at 40.

⁸⁶ See Pope Pius XII, *supra* note 30, at 329.

⁸⁷ *Cruzan v. Dir. Mo. Dep't of Health*, 497 U.S. 261, 293 (1990) (Scalia, J., concurring).

⁸⁸ Pope, *Medical Futility Statutes*, *supra* note 81, at 40.

⁸⁹ Eric Gampel, *Does Professional Autonomy Protect Medical Futility Judgments?*, 20 *BIOETHICS* 92, 95 (2006).

⁹⁰ See, e.g., Truog, *supra* note 11, at 987.

⁹¹ See Pope, *Medical Futility Statutes*, *supra* note 81, at 41-42.

⁹² Aghabarary & Dehghan, *supra* note 64.

⁹³ *Id.*

Patient autonomy is fundamental to medical decision-making.⁹⁴ When the patient is incompetent, this power passes to the surrogate, often the family.⁹⁵ By judging futility only from one perspective, all the power is given to the doctors who, under the definitional approach, are not required to inform the surrogate of treatment options.⁹⁶ The value judgment about a human being's worth and their quality of life are based on percentages, calculated impassively by a doctor.⁹⁷ When the question of "who has the power to demand treatment and who has the power to say no"⁹⁸ is judged by the definitional approach, it is the doctor who holds all the power. The viewpoint of those who know the patient best—namely, the family—is excluded.⁹⁹ This faulty allocation of decision-making power eventually led to the abandonment of the definitional approach for a new, process-based approach. Unfortunately, the same problem of a faulty allocation of decision-making power still cripples the new process-based approach.

III. THE PROCESS-BASED APPROACH TO MEDICAL FUTILITY

With little consensus about "what sort of life, what sort of existence, is worth the deployment of medical resources,"¹⁰⁰ the definitional approach to medical futility suggested by Schneiderman became controversial.¹⁰¹ Schneiderman's definitional approach failed to properly balance the competing factors in medical futility disputes and could not properly justify physicians making value-laden decisions.¹⁰² In 1999, the Council on Ethical and Judicial Affairs of the American Medical Association (the Council) noted the difficulty in defining "futile intervention."¹⁰³ Instead, the Council proposed a process-based approach to "determining, and subsequently withholding or withdrawing, what is felt to be futile care."¹⁰⁴

The process-based approach seeks to balance the different competing aspects of the definitional approach and provide a process to resolve medical futility cases—an area where the "absolute rule" from the

⁹⁴ See Kathleen M. Boozang, *An Intimate Passing: Restoring the Role of Family and Religion in Dying*, 58 U. PITT. L. REV. 549, 565 (1997).

⁹⁵ See *id.* at 566–67.

⁹⁶ Schneiderman et al., *Medical Futility: Its Meaning*, *supra* note 41, at 949.

⁹⁷ *Id.* at 950.

⁹⁸ Truog, *supra* note 11, at 987.

⁹⁹ See Aghabarary & Dehghan, *supra* note 64.

¹⁰⁰ Pope, *Dispute Resolution Mechanisms*, *supra* note 19, at 367.

¹⁰¹ Robert Sibbald, James Downar & Laura Hawryluck, *Perceptions of "Futile Care" Among Caregivers in Intensive Care Units*, 177 CAN. MED. ASS'N J. 1201, 1205 (2007).

¹⁰² Pope, *Dispute Resolution Mechanisms*, *supra* note 19, at 367.

¹⁰³ Council on Ethical and Judicial Affairs, *Medical Futility in End-of-Life Care*, 281 J. AM. MED. ASS'N 937, 937 (1999).

¹⁰⁴ *Id.* at 940.

definitional approach failed.¹⁰⁵ This approach contains features similar to the hearings and proceedings in traditional court cases because, while “a perfect and objective reconstruction of a case” and an objective futility determination “can be impossible,” such proceedings can give the decision-makers a better understanding of the issues.¹⁰⁶

The TADA has served as a leading model for the process approach to dispute resolution,¹⁰⁷ and several states have taken steps to replicate the TADA and adopt it as their dispute resolution mechanism.¹⁰⁸ The TADA shares several of the key characteristics of the procedure suggested by the Council, including the establishment of an ethics committee,¹⁰⁹ attempts to transfer care to those willing to provide treatment for the patient,¹¹⁰ and final termination of futile care.¹¹¹ The TADA serves as an illustrative model to demonstrate the faulty allocation of decision-making power inherent in the process-based approach to futility disputes.

The TADA arose out of a procedure to resolve medical futility disputes proposed by several major hospitals in Houston, Texas.¹¹² The goal was to unite healthcare providers under a common policy to protect themselves, both ethically and legally.¹¹³ However, this was impractical because the policy had no legal force and thus failed to give doctors protection from malpractice suits.¹¹⁴

In February 1997, the TADA, which incorporated the Houston hospitals’ dispute resolution procedures, was passed through the Texas Senate¹¹⁵ and the House¹¹⁶ but was vetoed by Governor George W. Bush.¹¹⁷ Governor Bush vetoed the bill because it contained “several provisions that would permit a physician to deny life-sustaining medical treatment to a

¹⁰⁵ *Id.* at 937.

¹⁰⁶ *Id.* at 939.

¹⁰⁷ Pope, *Procedural Due Process*, *supra* note 13, at 95.

¹⁰⁸ *Id.* at 107–08 (stating that Idaho, Virginia, and New Jersey have attempted to copy the TADA and that other professional organizations have endorsed the TADA, including medical associations in California, North Carolina, Washington, and Wisconsin, as well as the New York State Bar Association and other organizations in Maryland and Connecticut).

¹⁰⁹ Council on Ethical and Judicial Affairs, *supra* note 103, at 939.

¹¹⁰ *Compare id.* (“[An] arrangement may be made for transfer to another physician within the institution If this path is taken, the transferring institution should be supportive and helpful in the process and the accepting institution and physicians should be comfortable honoring the patient’s and/or proxy’s wishes.”), *with* TEX. HEALTH & SAFETY CODE ANN. § 166 (West 2019).

¹¹¹ Council on Ethical and Judicial Affairs, *supra* note 103, at 939.

¹¹² Pope, *Procedural Due Process*, *supra* note 13, at 111.

¹¹³ *Id.* at 111–12.

¹¹⁴ *Id.*

¹¹⁵ S. 75-13, 75th Sess., at 227 (Tex. 1997).

¹¹⁶ H.R. 75-84, 75th Sess., at 3861 (Tex. 1997).

¹¹⁷ Proclamation by the Governor of the State of Texas (June 20, 1997).

patient who desired them.”¹¹⁸ Additionally, the bill in its original form would eliminate the “objective standard” for reviewing certain physician conduct and instead replace it with a “subjective ‘good faith’ standard.”¹¹⁹ The bill was modified to revise the sections that concerned Governor Bush, and it went into effect on September 1, 1999.¹²⁰

While the TADA is a lengthy and complex document, the section on resolving medical futility disputes is comparatively short.¹²¹ The dispute resolution mechanism is triggered when the patient or surrogate requests life-sustaining treatment, but the “doctor believes that it is not medically appropriate.”¹²² Once the physician refuses to comply and deliver the requested treatment, the dispute will be reviewed by the healthcare facilities ethics committee.¹²³ Ethics committees are often composed of nurses, doctors, hospital staff, and members of the community.¹²⁴ While the case is before the ethics committee, the TADA requires that life-sustaining treatment be maintained for the patient.¹²⁵ The patient or surrogate must receive notification of the review by the ethics committee within forty-eight hours of a meeting about the case.¹²⁶ The surrogate is entitled to attend the meeting but is not entitled to participate or advocate for the patient.¹²⁷ Once a decision has been reached during the review process, the ethics committee must provide the surrogate with a written explanation of its decision.¹²⁸ If the committee and the attending physician both agree that life-sustaining treatment is inappropriate, and the surrogate still insists on continuing treatment, then attempts will be made to transfer the patient to another healthcare provider.¹²⁹

The physician or healthcare facilities must provide the surrogate with a list of alternative facilities that may be willing to accept the patient.¹³⁰ However, transfer to another facility is generally unlikely because other facilities are often unwilling to take cases already embroiled in a futility dispute.¹³¹ The surrogate has ten days to find an alternative healthcare provider willing to accept the patient, during which time life-sustaining

¹¹⁸ *Id.*

¹¹⁹ *Id.*

¹²⁰ See TEX. HEALTH & SAFETY CODE ANN. § 166 (West 2019).

¹²¹ *Id.* § 166.046(e).

¹²² *Id.* § 166.052.

¹²³ *Id.*

¹²⁴ Truog, *supra* note 11, at 1000.

¹²⁵ § 166.052.

¹²⁶ *Id.*

¹²⁷ *Id.*

¹²⁸ *Id.*

¹²⁹ *Id.* § 166.046(d).

¹³⁰ *Id.*

¹³¹ Truog, *supra* note 11, at 1001.

treatment will be continued.¹³² The ten-day waiting period begins once the ethics committee delivers its written decision stating that life-sustaining treatment is no longer appropriate.¹³³ In the unlikely event that the surrogate does find another facility willing to accept the patient, the patient is responsible for the cost of the transfer.¹³⁴

If, at the end of the ten-day waiting period, an alternative healthcare provider has not been found, the healthcare facility will continue to administer pain management treatment but is no longer obligated to provide life-sustaining medical treatment.¹³⁵ The facility may even remove nutrition and hydration if the physician believes that it would, among other factors, “hasten the patient’s death” or “be medically ineffective in prolonging life”¹³⁶

The only point at which the surrogate has the right to intervene on behalf of the patient is during the ten-day waiting period.¹³⁷ During this period, the surrogate may petition the court to extend the waiting period but only if “the court finds that there is a reasonable expectation that the [surrogate] may find a physician or health care facility willing to provide life-sustaining treatment if the extension is granted.”¹³⁸

In the process-based approach to resolving medical futility disputes under the TADA, the ultimate decision-maker between the physician and the surrogate is the ethics committee.¹³⁹ The ethics committee is the sole arbitrator of the merits of the futility dispute between the doctor and the surrogate,¹⁴⁰ and it acts as “a surrogate judge and jury, with the statutory power to authorize clinicians to take life or death actions against the wishes of a patient or family.”¹⁴¹ The same problem of faulty allocation of decision-making power discussed above with the definitional approach arises again because the TADA allocates all of the decision-making power to the ethics committee, and almost no power or influence is reserved for the family or surrogate.¹⁴²

Firstly, while the TADA has been held up as a due process approach to futility dispute resolution,¹⁴³ it fails to provide the patient and

¹³² § 166.052.

¹³³ *Id.*

¹³⁴ *Id.*

¹³⁵ *Id.*

¹³⁶ *Id.*

¹³⁷ *Id.*

¹³⁸ *Id.*

¹³⁹ *Id.*

¹⁴⁰ *Id.*

¹⁴¹ Truog, *supra* note 11, at 1000.

¹⁴² *See* § 166.

¹⁴³ Pope, *Procedural Due Process*, *supra* note 13, at 129.

the surrogate with the fundamental right to be heard.¹⁴⁴ The Supreme Court has continually noted that “an essential component of procedural [due process] is an opportunity to be heard.”¹⁴⁵ Under the TADA, in life-and-death situations, the patient and surrogate have no right to be heard by the ethics committee.¹⁴⁶ They may be present during the meeting and must receive a written report of the decision and medical reports, but they have no right to participate or advocate for the patient.¹⁴⁷ This structure fails to comport with the “fundamental requirement” outlined by the Supreme Court for due process because the patient and surrogate are denied their right to be heard and have no statutory mechanism for making their wishes and concerns known to the ethics committee.¹⁴⁸

Secondly, in addition to denying the surrogate their right to be heard, the ethics committee under the TADA lacks another fundamental feature of due process: appellate review.¹⁴⁹ As Thaddeus Mason Pope noted, “procedural due process requires ‘meaningful appellate review.’”¹⁵⁰ In the case of futility disputes, appellate review is critically necessary and “‘meaningful’ if it prevents the arbitrary deprivation of life or liberty.”¹⁵¹ The ethics committee’s decisions are, by definition and design, life-or-death decisions because they determine whether life-sustaining treatment will be continued.¹⁵²

For example, in court decisions regarding death penalty cases, where life-and-death decisions are made, the courts impose a “thoughtful and effective appellate review, focusing upon the circumstances present in each particular case.”¹⁵³ In medical futility cases, where the dispute centers around treatment that “sustains the life of a patient and without which the patient will die,” a decision to remove treatment by the ethics committee is almost assuredly final and irrevocable, for it results in the patient’s death.¹⁵⁴ Under the structure outlined by the TADA, the courts can only intervene

¹⁴⁴ See generally § 166.052; see also Pope, *Procedural Due Process*, *supra* note 13, at 146–47.

¹⁴⁵ *Crane v. Kentucky*, 476 U.S. 683, 690 (1986).

¹⁴⁶ See § 166.052.

¹⁴⁷ *Id.*

¹⁴⁸ *Lee v. Illinois*, 476 U.S. 530, 540 (1986). As noted by Pope, hospitals in Texas are free to allow surrogate participation and have allowed surrogates the ability to confront and cross-examine but no provision of the TADA explicitly gives the surrogates this right. Pope, *Procedural Due Process*, *supra* note 13, at 147.

¹⁴⁹ See § 166.052.

¹⁵⁰ Pope, *Procedural Due Process*, *supra* note 13, at 135 (citing *Parker v. Dugger*, 498 U.S. 308, 321 (1991)).

¹⁵¹ *Id.*

¹⁵² See § 166.052.

¹⁵³ *Pulley v. Harris*, 465 U.S. 37, 53 (1984).

¹⁵⁴ See § 166.052.

and provide appellate review in order to extend the ten-day waiting period.¹⁵⁵ They are not able to review the actual futility determination or the process employed by the ethics committee.¹⁵⁶ Hospitals and their ethics committees have “near-absolute (unreviewable) power over when to terminate treatment.”¹⁵⁷

In addition to granting the ethics committee near-absolute power over the life and death of the patient, the TADA provides no guidance on the composition of the committee.¹⁵⁸ Pope notes that a “fair tribunal is a basic requirement of due process” and requires a “neutral and detached judge.”¹⁵⁹ Ethics committees are far from neutral, as they are made up of physicians, nurses, and other hospital staff, and are augmented by “community members” who are “often grateful patients of the hospital.”¹⁶⁰ They are “insiders” who have the mindset of the hospital and act in the best interest of the institution, not the individual.¹⁶¹ Thus, while the TADA seeks to attain a due-process-based resolution, it places the power of life-and-death decisions firmly in the hands of a committee with no appellate review and a bias in favor of the hospital,¹⁶² and with no input or advocacy for the patient by the surrogate. This lack of due process arises out of a more fundamental problem shared with the definitional approach: the faulty allocation of decision-making power solely into the hands of the ethics committee.¹⁶³ The primary issue still remains, namely, “who has the power to demand treatment, and who has the power to say no.”¹⁶⁴ Under the TADA, as well as under the definitional approach, it is hospital insiders and not those with an intimate knowledge of the patient who make the ultimate decision over life and death.

IV. THE PRECAUTIONARY PRINCIPLE

The problem of a faulty allocation of decision-making power can be solved, or at least mitigated, by integrating the precautionary principle, a standard of environmental law, into medical futility disputes. Essentially, the precautionary principle would give patients and surrogates decision-making power and require physicians to prove their case in front of a neutral court.¹⁶⁵

¹⁵⁵ *Id.*

¹⁵⁶ *Id.*

¹⁵⁷ Pope, *Procedural Due Process*, *supra* note 13, at 136.

¹⁵⁸ *Id.* at 118, 132.

¹⁵⁹ *Id.* at 131–32.

¹⁶⁰ Truog, *supra* note 11, at 1000.

¹⁶¹ *Id.*

¹⁶² *Id.* at 1002.

¹⁶³ *Id.* at 987.

¹⁶⁴ *Id.*

¹⁶⁵ *See supra* pp. 24–26; *see also infra* pp. 28–29.

Before considering how the precautionary principle can accomplish this, it is important to understand what the precautionary principle is.

The precautionary principle is a decision-making tool used in environmental law and regulation that seeks to balance science, ethics, politics, and the law to achieve “pro-active environmental protection and management.”¹⁶⁶ There are many different formulations of this principle, but one common formulation comes from the World Health Organization, which has stated that “in cases of serious or irreversible threats to the health of humans or ecosystems, acknowledged scientific uncertainty should not be used as a reason to postpone preventive measures.”¹⁶⁷ In other words, when there is a risk of serious harm, preventative measures should be used until it is scientifically certain that no harm will occur.¹⁶⁸ The precautionary principle embodies the adage coined by Benjamin Franklin, “a stitch in time saves nine.”¹⁶⁹

There are three aspects of the precautionary principle that make it an ideal tool to use in medical futility disputes. Firstly, the precautionary principle is triggered when future harm becomes a possibility.¹⁷⁰ The harm involved is not a present or existing harm but is one that could occur at some future date.¹⁷¹ Because the precautionary principle is essentially a “stop and think” approach, the risk of harm must still be in the future.¹⁷²

Secondly, the risk of harm contemplated in the precautionary principle must be a serious risk.¹⁷³ The degree of risk serves two purposes: firstly, it serves as a trigger for the precautionary principle,¹⁷⁴ and secondly, it justifies shifting the burden of proof to the party causing the risk.¹⁷⁵ Some critics of the precautionary principle have pointed out that the indefinite nature of the potential harm would cripple the current system of regulation and growth.¹⁷⁶ Other critics have stated that having a low level of risk serving

¹⁶⁶ INTERPRETING THE PRECAUTIONARY PRINCIPLE 12 (Timothy O’Riorden & James Cameron eds., 1994).

¹⁶⁷ Marco Martuzzi & Joel A. Tickner, *Introduction — The Precautionary Principle: Protecting Public Health, the Environment and the Future of Our Children*, in THE PRECAUTIONARY PRINCIPLE: PROTECTING PUBLIC HEALTH, THE ENVIRONMENT AND THE FUTURE OF OUR CHILDREN 7 (Marco Martuzzi & Joel A. Tickner ed., 2004), https://www.euro.who.int/__data/assets/pdf_file/0003/91173/E83079.pdf [https://perma.cc/T2X6-FKGM].

¹⁶⁸ *See id.*

¹⁶⁹ *A stitch in time saves nine*, CAMBRIDGE DICTIONARY (4th ed. 2013).

¹⁷⁰ *See* Noah M. Sachs, *Rescuing the Strong Precautionary Principle from Its Critics*, U. ILL. L. REV. 1285, 1312 (2011).

¹⁷¹ *See id.* at 1295.

¹⁷² *Id.* at 1296.

¹⁷³ *Id.*

¹⁷⁴ *See id.* at 1334.

¹⁷⁵ *See id.* at 1333.

¹⁷⁶ *See id.* at 1305.

as the trigger for the precautionary principle would cripple the parties in red tape and prevent useful and necessary development.¹⁷⁷ However, when the risk of harm rises to the level of “serious or irreversible damage,”¹⁷⁸ these concerns disappear¹⁷⁹ because the severity of the risk rises to such a point that it cannot be ignored or set aside.¹⁸⁰

Thirdly, there is the issue of scientific uncertainty inherent in the precautionary principle.¹⁸¹ In the realm of environmental impact, it can be difficult or even impossible to determine the full extent of a potential harm before the harm occurs.¹⁸² The World Health Organization stated that “this kind of uncertainty is inherent in novel or complex systems in which existing models do not apply.”¹⁸³ Currently, the party seeking to maintain the environmental status quo has the burden of proving “the fact of the pollution, the source, and the resulting harm.”¹⁸⁴ However, the precautionary principle allows regulators—those seeking to maintain the environmental status quo—to impose safety requirements, even when they are not able to come to a scientifically certain determination of what the potential risk could be.¹⁸⁵

Critics of the precautionary principle have stated that basing policy arguments on uncertainty rather than verified scientific hypotheses is “profoundly damaging to science and society.”¹⁸⁶ This view does not conform with a proper understanding of decision-making in the face of uncertainty.¹⁸⁷ The precautionary principle presupposes a situation where scientific certainty is lacking, and thus, seeking out scientific certainty when there is none to be had is illogical.¹⁸⁸ When a proposed action is irreversible and can have catastrophic consequences, then it is logical to employ

¹⁷⁷ *See id.*

¹⁷⁸ Lesley Wexler, *Limiting the Precautionary Principle: Weapons Regulation in the Face of Scientific Uncertainty*, 39 U.C. DAVIS L. REV. 459, 503 (2006).

¹⁷⁹ Sachs, *supra* note 171, at 1292.

¹⁸⁰ *See id.* at 1293.

¹⁸¹ *Id.* at 1295.

¹⁸² *See id.* at 1318.

¹⁸³ *See* Ted Schettler & Carolyn Raffensperger, *Why Is a Precautionary Approach Needed?*, in THE PRECAUTIONARY PRINCIPLE: PROTECTING PUBLIC HEALTH, THE ENVIRONMENT AND THE FUTURE OF OUR CHILDREN 70 (Marco Martuzzi & Joel A. Tickner ed., 2004), https://www.euro.who.int/__data/assets/pdf_file/0003/91173/E83079.pdf [<https://perma.cc/T2X6-FKGM>].

¹⁸⁴ James M. Olson, *Shifting the Burden of Proof: How the Common Law Can Safeguard Nature and Promote an Earth Ethic*, 20 ENVTL. L. 891, 899 (1990).

¹⁸⁵ *See* Schettler & Raffensperger, *supra* note 184, at 70.

¹⁸⁶ Gregory D. Fullem, *The Precautionary Principle: Environmental Protection in the Face of Scientific Uncertainty*, 31 WILLAMETTE L. REV. 495, 499 (1995) (quoting Patrick Michaels, *Environmental Rules Should Be Based on Science*, INSIGHT ON THE NEWS 1, 21 (Apr. 12, 1993)).

¹⁸⁷ *See id.*

¹⁸⁸ *See id.* at 501.

prudence even if there is some uncertainty as to the risk of harm.¹⁸⁹ Even a small risk of a sufficiently severe harm would provide the incentive for exercising caution.¹⁹⁰ For example, a thrill-seeker jumping out of a plane without a reserve parachute is considered reckless, not because it is unlikely that his first parachute will not open, but because of the dire consequences should the first fail.

While it is true that the precautionary principle does not incorporate a threshold for the severity of the harm required to trigger the principle, it is only meant to serve as a framework in which regulatory bodies and organizations function.¹⁹¹ It is up to the legislature to determine what level of risk is sufficient to trigger the principle.¹⁹²

While there are many different formulations of the precautionary principle, they can generally be grouped into two categories: the strong and weak principles.¹⁹³ An often-cited formulation of the weak precautionary principle was adopted by 172 countries (including the United States) at the Earth Summit in what became known as the Rio Declaration.¹⁹⁴ The declaration states that “[i]n order to protect the environment, the precautionary approach shall be widely applied by States according to their capabilities. Where there are threats of serious or irreversible damage, lack of full scientific certainty shall not be used as a reason for postponing cost-effective measures to prevent environmental degradation.”¹⁹⁵

On the other hand, Professor Noah M. Sachs provides a common formulation of the strong precautionary principle.¹⁹⁶ This two-part formulation states that:

- (1) regulation should presumptively be applied when an activity or product poses serious threats to human health or the environment, even if scientific uncertainty precludes a full understanding of the nature or extent of the threats;
- and (2) the burden of overcoming the presumption in favor

¹⁸⁹ *Id.*

¹⁹⁰ *Id.*

¹⁹¹ Sachs, *supra* note 171, at 1297.

¹⁹² *Id.*

¹⁹³ See Andrew Jordan & Timothy O’Riordan, *The Precautionary Principle: A Legal and Policy History*, in *THE PRECAUTIONARY PRINCIPLE: PROTECTING PUBLIC HEALTH, THE ENVIRONMENT AND THE FUTURE OF OUR CHILDREN* 1, 37 (2004), https://www.euro.who.int/__data/assets/pdf_file/0003/91173/E83079.pdf [<https://perma.cc/T2X6-FKGM>] (stating “Both advocates and critics generally agree on one thing: that precaution works along a continuum from quite “weak” formulations that are relatively protective of the status quo to very “strong” formulations.”).

¹⁹⁴ Sachs, *supra* note 171, at 1292.

¹⁹⁵ U.N. Conference on Environment and Development, *Rio Declaration on Environment and Development*, U.N. Doc. A/CONF.151/26/Rev.1 (Vol. 1), annex 1 (Aug. 12, 1992).

¹⁹⁶ Sachs, *supra* note 171, at 1288.

of regulation lies with the proponent of the risk-creating activity or product.¹⁹⁷

While both the weak and strong principles contain elements of risks of future harm, a risk of serious harm, and scientific uncertainty, there are several important differences.¹⁹⁸ The weak precautionary principle, as outlined in the Rio Declaration, permits but does not require regulatory bodies to impose preventative measures.¹⁹⁹ On the other hand, the strong precautionary principle states that preventative measures or “regulation[s] should *presumptively* be applied” when there is a serious threat to “human health or the environment.”²⁰⁰ This presumption favors those trying to protect the environment instead of those seeking to alter it.²⁰¹

Additionally, the strong precautionary principle imposes a reversal or shifting of the burden of proof.²⁰² This reversal of proof requires the party attempting to carry out the activity to prove that it will not cause harm before the activity is undertaken.²⁰³ This shifting of the burden is employed in the stronger versions of the precautionary principle because, with more weighty interests involved, the creators of the risk must be forced to properly analyze the risk and show that their actions will not cause harm.²⁰⁴

The precautionary principle also forces proponents of their activities to prove their case in front of the existing court system.²⁰⁵ For example, if the precautionary principle were codified under a federal statute, then the parties advocating for activities would have to prove their case in front of a court, just like those trying to limit regulatory action.²⁰⁶ Thus, both parties are brought before a neutral and fair tribunal to determine the merits of a precautionary principle dispute, providing for “a basic requirement of due process.”²⁰⁷

Finally, as the definition suggests, the final goal of the precautionary principle is to anticipate possible harms and mitigate them as much as possible.²⁰⁸ This idea is exemplified in the world of medicine by Hippocrates

¹⁹⁷ *Id.* at 1295.

¹⁹⁸ *Id.*

¹⁹⁹ *Id.*

²⁰⁰ *Id.* (emphasis added).

²⁰¹ Olson, *supra* note 185, at 899.

²⁰² Sachs, *supra* note 171, at 1296.

²⁰³ *Id.*

²⁰⁴ *Id.* at 1299.

²⁰⁵ See *Natural Res. Def. Council v. E.P.A.*, 859 F.2d 156, 170 (D.C. Cir. 1988) (“And, contrary to EPA’s assumption, the CWA does not empower the agency to regulate point sources themselves; rather, EPA’s jurisdiction under the operative statute is limited to regulating the discharge of pollutants.”).

²⁰⁶ See *id.*

²⁰⁷ *In re Murchison*, 349 U.S. 133, 136 (1955).

²⁰⁸ Sachs, *supra* note 171, at 1297.

who stated, “first, do no harm.”²⁰⁹ The precautionary principle is, first and foremost, a decision-making tool that requires the creators of an environmental risk to demonstrate that their proposed actions will not cause harm before the action is taken.²¹⁰

V. APPLYING THE PRECAUTIONARY PRINCIPLE TO MEDICAL FUTILITY

The precautionary principle applied to medical futility disputes helps solve the problem of faulty allocation of decision-making power by giving the surrogate the power to make treatment decisions and requiring the physician to prove his or her position before a neutral and detached tribunal. In medical futility disputes, the physician or other party seeking to terminate life-sustaining treatment is seeking to change the status quo,²¹¹ and thus, in precautionary principle terms, they are the party creating the risk.²¹² Conversely, the surrogate or party who desires to continue life-sustaining treatment is the party seeking to maintain the status quo,²¹³ similar to a regulatory body seeking to preserve environmental equilibrium under the precautionary principle.²¹⁴

Additionally, in a medical futility dispute, the risk involved is not specifically that the patient will die because, in the vast majority of cases, the patient does die.²¹⁵ Instead, the risk that the parties face is that of premature termination whereby, if the patient could be kept alive, advances in medicine could help restore the patient.²¹⁶

The precautionary principle is particularly well suited for use in medical futility disputes because of the severity of risk that triggers the principle.²¹⁷ The precautionary principle contains no specific gravity threshold to trigger the principle;²¹⁸ however, with futility disputes, the severity of the risk is sufficient to warrant precaution.²¹⁹ The Court in *Cruzan* noted that the “choice between life and death is a deeply personal decision

²⁰⁹ See *Precautionary Principle FAQs*, SCI. AND ENVTL. HEALTH NETWORK (Mar. 5, 2013), <https://www.sehn.org/sehn/precautionary-principle-faqs> [<https://perma.cc/N2MM-QNGF>].

²¹⁰ See Fullem, *supra* note 187, at 501 (quoting Patrick Michaels, *Environmental Rules Should Be Based on Science*, INSIGHT ON THE NEWS, Apr. 12, 1993, at 21).

²¹¹ See *Cruzan v. Dir. Mo. Dep’t of Health*, 497 U.S. 261, 283 (1990) (stating that “[a]n erroneous decision not to terminate results in a maintenance of the status quo . . .”).

²¹² See Sachs, *supra* note 171, at 1295.

²¹³ *Cruzan*, 497 U.S. at 283.

²¹⁴ Olson, *supra* note 185, at 899.

²¹⁵ Pope, *Procedural Due Process*, *supra* note 13, at 97.

²¹⁶ See *Cruzan*, 497 U.S. at 283.

²¹⁷ Sachs, *supra* note 171, at 1296.

²¹⁸ *Id.* at 1297.

²¹⁹ See *Cruzan*, 497 U.S. at 283 (discussing the severity of risk required to warrant precautions in medical disputes involving vegetative states).

of obvious and overwhelming finality.”²²⁰ These “serious or irreversible damages” are exactly what the precautionary principle is designed to protect.²²¹

Under the precautionary principle, the party who creates the risk and carries out the activity—in the context of medical futility, premature termination—has the burden of proving that such actions will not cause harm.²²² Applying this principle to medical futility disputes, the physician would have the burden of showing that removing life-sustaining treatment will not cause the premature death of the patient because it is the removal of treatment that creates a risk of premature death.²²³

Shifting the burden to the party who causes the risk in medical futility cases has already been approved by the Supreme Court in *Cruzan*.²²⁴ While the roles were reversed—the family seeking termination and the physicians opposing—the Court noted that those who were seeking termination of treatment were creating a “risk of an erroneous decision.”²²⁵ The Court found it proper for the state of Missouri to place a “more stringent burden of proof” on the parties causing the risk of premature termination, instead of burdening those advocating for the maintenance of the status quo.²²⁶

Applying the precautionary principle to medical futility disputes would have a similar effect, placing “the onus . . . on the proponent [the physician] to prove that an activity is safe [avoids premature termination] rather than for its opponents [the surrogates] to prove that it is unsafe.”²²⁷ Thus, in order for the doctor to terminate care, he or she would have to meet or exceed a specified burden of proof.²²⁸

²²⁰ *Id.* at 281.

²²¹ Wexler, *supra* note 179, at 503.

²²² See Sachs, *supra* note 171, at 1295 (“Furthermore . . . the Strong Precautionary Principle explicitly places the burden on the private proponent of the risk-creating activity to overcome the default by proving that the risks are acceptable or reasonable.”).

²²³ See *id.*

²²⁴ See *Cruzan*, 497 U.S. at 284 (“In sum, we conclude that a State may apply a clear and convincing evidence standard in proceedings where a guardian seeks to discontinue nutrition and hydration of a person diagnosed to be in a persistent vegetative state.”).

²²⁵ *Id.* at 268.

²²⁶ *Id.*

²²⁷ Neil Pearce, *Public Health and the Precautionary Principle*, in THE PRECAUTIONARY PRINCIPLE: PROTECTING PUBLIC HEALTH, THE ENVIRONMENT AND THE FUTURE OF OUR CHILDREN 49, 57 (2004), https://www.euro.who.int/__data/assets/pdf_file/0003/91173/E83079.pdf [https://perma.cc/T2X6-FKGM].

²²⁸ Truog, *supra* note 11, at 1000.

This shift in the burden to the physician is contrary to how traditional medical futility disputes are generally decided.²²⁹ Under the definitional approach, doctors have all the decision-making power, and the surrogate has an almost insurmountable burden to overcome if they want to disprove the doctor because the futility determinations can be made without the surrogate's input.²³⁰ Under the process-based approach outlined in the TADA, the doctors still generally have the ultimate decision-making power because the hospital ethics committees almost always side with the hospital and their doctors.²³¹ By incorporating the precautionary principle, the family or surrogate would retain more decision-making power because the physicians would be forced to prove their case in court prior to terminating life support.²³² Thus, the family, who generally knows the patient's wishes and values best, would presumptively hold the power to make the critical value-laden decisions required in a medical futility dispute.²³³

Applying the precautionary principle to medical futility does not necessarily mean that physicians can never withhold medically futile treatment.²³⁴ Instead, the physicians would have to "make a persuasive case for what they wish to do and must accept responsibility for it."²³⁵

Incorporating the precautionary principle into the medical futility debate should also involve a neutral and detached arbitrator for the disputes between physician and surrogate.²³⁶ As with traditional regulatory challenges, challenges to the precautionary principle are brought into court to be decided by a judge.²³⁷ Similarly, futility disputes should not be brought to a panel of hospital insiders.²³⁸ Rather, they should be treated like other disputes.²³⁹ Pope noted that due process in a medical futility dispute requires a "neutral and detached judge."²⁴⁰ Bringing these disputes before a judge, just like an environmental challenge, would ensure an unbiased tribunal and better achieve the goals of due process.²⁴¹

²²⁹ See, e.g., Darren P. Marciniess, *A Comparison of Cruzan and Schiavo the Burden of Proof, Due Process, and Autonomy in the Persistently Vegetative Patient*, 26 J. LEGAL MED. 233, 243 (2005).

²³⁰ See generally Schneiderman et al., *Medical Futility: Its Meaning*, *supra* note 41, at 951.

²³¹ Truog, *supra* note 11, at 1000.

²³² *Id.*

²³³ Pearce, *supra* note 228, at 57.

²³⁴ Schettler & Raffensperger, *supra* note 184, at 78.

²³⁵ *Id.*

²³⁶ See Pope, *Procedural Due Process*, *supra* note 13, at 131.

²³⁷ See *Natural Res. Def. Council v. E.P.A.*, 859 F.2d 156, 170 (D.C. Cir. 1988) (illustrating where the court has the power and authority to limit the EPA's regulatory authority).

²³⁸ Pope, *Procedural Due Process*, *supra* note 13, at 133.

²³⁹ Truog, *supra* note 11, at 1000.

²⁴⁰ Pope, *Procedural Due Process*, *supra* note 13, at 62.

²⁴¹ See Truog, *supra* note 11, at 1001.

Consider the far-reaching effect that the precautionary principle would have in the case of Tinslee Lewis, as discussed in the introduction. Tinslee's mother, who is already burdened by the possibility of losing her child, would not have to pursue her case through the Texas Court of Appeals.²⁴² Instead, the physicians who want to terminate the only treatment keeping Tinslee alive would have the burden of pursuing their case against Tinslee.²⁴³ Through their attempts to remove life support, Tinslee's physicians are creating a risk of "serious or irreversible damage,"²⁴⁴ which is the risk that the child will die before a cure is found.²⁴⁵ The precautionary principle would require the physicians to prove that they will not cause any harm, not before a biased committee of hospital insiders,²⁴⁶ but in front of a neutral and impartial court.²⁴⁷ Doing so would guarantee baby Tinslee the due process she deserves.²⁴⁸

There is no question that Tinslee Lewis will die. Even Tinslee's mother stated, "I know that everybody has to pass away, but my fear is them pulling the plug on her with me not being able to make the decision first."²⁴⁹ Applying the precautionary principle to her medical futility dispute would give the decision-making power to Tinslee's mother, who is trying to preserve her life. Under the precautionary principle, this ability to make medical decisions would be restored to Tinslee's mother, instead of being given to physicians playing god, choosing life or death for Tinslee.

²⁴² See Pearce, *supra* note 228, at 57.

²⁴³ Sachs, *supra* note 171, at 1295.

²⁴⁴ Wexler, *supra* note 179, at 503.

²⁴⁵ See *Cruzan v. Dir. Mo. Dep't of Health*, 497 U.S. 261, 283 (1990) (stating that "the possibility of subsequent developments such as advancements of medical science . . . create the potential that a wrong decision will eventually be corrected or its impact mitigated . . .").

²⁴⁶ Truog, *supra* note 11, at 1000.

²⁴⁷ *In re Murchison*, 349 U.S. 133, 136 (1955).

²⁴⁸ *Id.*

²⁴⁹ Kaley Johnson, *Mom of Baby on Life Support at Cook Children's Gives Update on Legal Battle, Condition*, FORT WORTH STAR-TELEGRAM (Jan. 6, 2020, 5:21 PM), <https://www.star-telegram.com/news/local/fort-worth/article239004823.html> [<https://perma.cc/PX5M-L999>].

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